Subject: Studies in the News: (September 28, 2007)

Studies in the News for

California Department of Mental Health

Introduction to Studies in the News

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The following are the Subject Headings included in this issue:

Children and Adolescent Mental Health
First Episode Psychosis
Mental Health Policies
Mentally Ill Homeless
Suicide Prevention
Trauma/Posttraumatic Stress Disorder

The following studies are currently on hand:

CHILDREN AND ADOLESCENT MENTAL HEALTH

"Children's' Unique Experience of Depression: Using a Developmental Approach to Predict Variation Symptomology." By Misty M. Ginicola, Yale University. IN: Child and Adolescent Psychiatry and Mental Health, vol. 1 (August 2007) pp. 1-26.

["Current clinical knowledge suggests that children can have different types of depressive symptoms (irritability and aggression), but presents no theoretical basis for these differences. Using a developmental approach, the present study sought to test the relationship between developmental level (mental age) and expression of depressive symptoms. The primary hypothesis was that as children's mental age increased so would the number of internalizing symptoms present.

Participants were 252 psychiatric inpatients aged 4 to 16 with a diagnosed depressive disorder. All children were diagnosed by trained clinicians using DSM criteria. Patients were predominantly male (61%) with varied ethnic backgrounds (Caucasian 54%; African American 22%; Hispanic 19%; Other 5%). Children were given an IQ test (KBIT or WISC) while within the hospital. Mental age was calculated by using the child's IQ score and chronological age. Four trained raters reviewed children's records for depressive symptoms as defined by the DSM-IV TR. Additionally, a ratio score was calculated to indicate the number of internalizing symptoms to total symptoms.

Mental age positively correlated (r = .51) with an internalizing total symptom ratio score and delineated between several individual symptoms. Mental age also predicted comorbidity with anxiety and conduct disorders. Children of a low mental age were more likely to be comorbid with conduct disorders, whereas children with a higher mental age presented more often with anxiety disorders. Gender was independently related to depressive symptoms, but minority status interacted with mental age."]

Full text at: http://www.capmh.com/content/pdf/1753-2000-1-9.pdf

[Request #S07-106-849]

FIRST EPISODE PSYCHOSIS

"Out Back and Out-of-Whack: Issues Related to the Experience of Early Psychosis in the New England Region, New South Wales, Australia." By Rhonda L. Wilson, Hunter New England Health, New South Wales, Australia. IN: Rural and Remote Health: The International Electronic Journal of Rural and Remote Health Research, Education, Practice and Policy, vol. 7, no. 715 (September 18, 2007) pp.1-6.

["The slow slide into a first episode of psychosis is often difficult to detect and is often described in retrospect as the point at which things were not quite right. A rural setting

can add a layer of complexity to detecting early psychosis, with local structural issues and other disadvantages potentially complicating both identification and early treatment. Fewer specialist workers are available in rural communities compared with urban communities, and drug and alcohol usage can mask the early signs of prodrome (early psychosis symptoms). Along with these more predictable contextual issues, family and drought conditions can impact significantly the mental health of vulnerability rural populations. The use of a vignette provides a window to the lived experience of early psychosis in rural communities. This article explores these issues in the context of northern New South Wales, Australia."]

Full text at: http://www.rrh.org.au/publishedarticles/article_print_715.pdf

[Request #S07-106-850]

MENTAL HEALTH POLICIES

The Department of Defense Plan to Achieve the Vision of the DoD Task Force on Mental Health: Report to Congress. By the U. S. Department of Defense. (The Department, Washington, DC) September 2007. 37 p.

["The Department of Defense (DoD) Task force on Mental Health, established by Section 723 of the National Defense Authorization Act for Fiscal Year 2006, delivered its report of findings on June 12. That report contained 95 recommendations and a strong positive vision that called for a cultural change to improve and enhance the psychological health and fitness of all our Active and Reserve component Service members as well as their families. The DoD has embraced the vision and the spirit embodied in the recommendations.

We recognize that the Global War on Terror has raised questions about the adequacy of psychological health services and service delivery systems established by DoD during the Cold War era. We accept the responsibility to make the changes needed to provide the highest possible level of care and support of our military community. A roadmap for change has been offered to us not only by the Mental Health Task Force, but also by other independent external review groups as well as internal review procedures. We appreciate the efforts of the dedicated citizens who identified ways to improve our system of care. To address these recommendations, we envision an end state that provides a comprehensive integrated system of excellence in prevention and care that flexes to meet the needs of individual Service members and their families, looking through their eyes, across the military lifecycle."]

Full text at: http://www.ha.osd.mil/asd/downloads/MHTF-Report-to-Congress.pdf

[Request #S07-106-851]

IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings. By the Inter-Agency Standing Committee. (The Committee, Geneva, Switzerland) June 2007. 99 p.

["Armed conflicts and natural disasters cause significant psychological and social suffering to affected populations. The psychological and social impacts of emergencies may be acute in the short term, but they can also undermine the long-term mental health and psychosocial well-being of the affected population. These impacts may threaten peace, human rights and development. One of the priorities in emergencies is thus to protect and improve people's mental health and psychosocial well-being. Achieving this priority requires coordinated action among all government and non-government humanitarian actors.

A significant gap, however, has been the absence of a multi-sectoral, inter-agency framework that enables effective coordination, identifies useful practices and flags potentially harmful practices, and clarifies how different approaches to mental health and psychosocial support complement one another. This document aims to fill that gap.

These guidelines reflect the insights of practitioners from different geographic regions, disciplines and sectors, and reflect an emerging consensus on good practice among practitioners. The core idea behind them is that, in the early phase of an emergency, social supports are essential to protect and support mental health and psychosocial well-being. In addition, the guidelines recommend selected psychological and psychiatric interventions for specific problems."]

Full text at;
http://www.who.int/mental_health/emergencies/guidelines_iasc_mental_health_psychosocial_june_2007.pdf

[Request #S07-106-852]

Senate Passes Mental Health Parity Bill. By News Staff. IN: American Academy of Family Physicians (AAFP) News Now. (September 26, 2007) 1 p.

["Under a bill recently passed by the Senate, health insurers would be required to provide the same level of coverage for the treatment of mental illnesses as they do for physical ailments.

The legislation, S.B. 558, (at the THOMAS Web site, type 'S 558' in the search box after selecting 'Bill Number') which is known as the Mental Health Parity Act of 2007, does not mandate that health plans provide coverage for mental illness. However, if insurers *do* provide this type of coverage, they would have to provide coverage that is equal in amount and scope to other benefits offered under that insurer's plans, according to the legislation passed by the Senate on Sept. 18.

The bill does not apply to companies with fewer than 50 employees, and it would provide

exemptions if coverage costs for mental illness and substance abuse exceeded certain levels. Specifically, the legislation would exempt group health plans and companies if their costs for covering treatment of mental illnesses and substance abuse were to exceed 2 percent of total plan costs in the first year or 1 percent in subsequent years. It also would not preempt state mental health parity laws."]

Full text at: http://www.aafp.org/online/en/home/publications/news/news-now/government-medicine/20070926mentalhealthbill.printerview.html

[Request #S07-106-853]

"Resources for Mental Health: Scarcity, Inequity, and Inefficiency." By Saxena Shekhar, World Health Organization, and others. IN: The Lancet, vol. 370 (September 2007) pp. 878-889.

["Resources for mental health include policy and infrastructure within countries, mental health services, community resources, human resources, and funding. We discuss here the general availability of these resources, especially in low-income and middle-income countries.

Government spending on mental health in most of the relevant countries is far lower than is needed, based on the proportionate burden of mental disorders and the availability of cost-effective and affordable interventions. The poorest countries spend the lowest percentages of their overall health budgets on mental health. Most care is now institutionally based, and the transition to community care would require additional funds that have not been made available in most countries. Human resources available for mental health care in most low-income and middle-income countries are very limited, and shortages are likely to persist.

Not only are resources for mental health scarce, they are also inequitably distributed-between countries, between regions, and within communities. Populations with high rates of socioeconomic deprivation have the highest need for mental health care, but the lowest access to it. Stigma about mental disorders also constrains use of available resources. People with mental illnesses are also vulnerable to abuse of their human rights.

Inefficiencies in the use of available resources for mental health care include allocative and technical inefficiencies in financing mechanisms and interventions, and an over concentration of resources in large institutions. Scarcity of available resources, inequities in their distribution, and inefficiencies in their use pose the three main obstacles to better mental health, especially in low-income and middle-income countries." **NOTE: Journal available for loan**.]

Full text at: http://download.thelancet.com/pdfs/journals/0140-6736/PIIS0140673607612392.pdf

[Request #S07-106-854]

Screening and Entry into Mental Health Treatment: Balancing Help for the Individual and the Community. By the National Conference of State Legislatures. (The Conference, Washington, DC) September 10, 2007. 6 p.

["The National Institute of Mental Health estimates that one in 10 children suffer from mental illness severe enough to result in significant functional impairment. An estimated 26.2 percent of Americans ages 18 and older and about one in four adults suffer from a diagnosable mental disorder in a given year. Even though we have made marked progress in recent years in identifying and providing services to individuals with mental illness, the fact remains that nearly two-thirds of all individuals with a diagnosable mental disorder fail to seek treatment due to the stigma associated with mental illness….

After the Virginia Tech shootings in the spring of 2007, community leaders found themselves grappling with the question of how to balance helping those with mental illness while at the same time assuring the safety of the community and preserving privacy and liberty for the individual. In the next year many state legislatures will consider these questions and more as they examine their existing state systems and how they provide for the needs of all populations."]

Full text at: http://www.ncsl.org/programs/health/forum/screening.htm

[Request #S07-106-855]

Shock Therapy Makes a Comeback: States Respond. By Carla Curran, National Conference of State Legislatures. (The Conference, Washington, DC) September 17, 2007. 2 p.

["After decades of being regarded as a dangerous and sometimes misused procedure, electroconvulsive therapy has been improved since it was first introduced in the 1930's. Today, mental health authorities such as the American Psychiatric Association and Mental health America say that the therapy can be safe and effective.

Electroshock therapy or ECT is used to treat severely depressed patients when other forms of therapy have not worked. It is widely acknowledged that informed consent is as important in ECT as in other medical treatments. Nevertheless, because the treatment remains controversial, a growing number of states are passing bills to ensure that patients who may be candidates for ECT are protected."]

Full text at: http://www.ncsl.org/programs/health/shn/2007/sn499c.htm

[Request #S07-106-857]

MENTALLY ILL HOMELESS

The Applicability of Housing First Models to Homeless Persons with Serious Mental Illness: Final Report. By Carol L. Pierson, Walter R. MacDonald & Associates,

Inc., and others. (U.S. Department of Housing and Urban Development, Washington, DC) July 2007. 209 p.

["Understanding homelessness is a necessary step toward ending it, especially for those persons living with a chronic condition such as mental illness, an addiction, or physical disability. Ending chronic homelessness remains a national goal for President Bush, the Department of Housing and Urban Development (HUD), and many within the homeless advocacy community.

In recent years, an approach known as Housing First has emerged as one model for serving chronically homeless people. HUD began this study as a first step in describing how Housing First programs actually work and what sorts of short term outcomes are realized by the people they serve.

This report, *The Applicability of Housing First Models to Homeless Persons with Serious Mental Illness*, provides a basic description of several programs that represent a Housing First model. The report should help clarify the issues and inform the policy discussion about how best to address the most vulnerable in American society."]

Full text at: http://www.huduser.org/Publications/pdf/hsgfirst.pdf

[Request #S07-106-858]

SUICIDE PREVENTION

"Let's Not Talk About It: Suicide Inquiry in Primary Care." By Mitchell D. Feldman, University of California, San Francisco, and others. IN: Annals of Family Medicine, vol. 5, no. 5 (September/October 2007) pp. 412-417.

["The purpose of this study was to ascertain physician characteristics associated with exploring suicidality in patients with depressive symptoms and the influence of patient antidepressant requests.

Primary care physicians were randomly recruited from 4 sites in northern California and Rochester, NY; 152 physicians participated. Standardized patients portraying 2 conditions (Major depression and adjustment disorder) and 3 antidepressant request types (brand specific, general, or none) made unannounced visits to these physicians between May 2003 and May 2004. We examined factors associated with physician exploration of suicidality.

Conclusions reached from study were: when seeing patients with depressive symptoms, primary care physicians do not consistently require about suicidality. Their inquiries into suicidal thinking may be enhanced through advertising or public service messaging that prompts patients to ask for help. Research is needed to further elucidate physician characteristics associated with the assessment of suicidality."]

Full text at: http://www.annfammed.org/cgi/reprint/5/5/412

[Request #S07-106-859]

"Prediction and Prevention of Suicide in Patients with Unipolar Depression and Anxiety." By Xenia Gonda, National Institute of Psychiatry and Neurology, Budapest, Hungary, and others. IN: Annals of General Psychiatry, vol. 6, no. 23 (September 2007) pp. 1-17.

["Epidemiological data suggest that between 59 and 87% of suicide victims suffered from major depression while up to 15% of these patients will eventually commit suicide. Male gender, previous suicide attempt(s), comorbid mental disorders, adverse life-situation, acute psycho-social stressors etc. also constitute robust risk factors. Anxiety and minor depression present with a low to moderate increase in suicide risk but anxiety-depression comorbidity increases this risk dramatically.

Contrary to the traditional psychoanalytic approach which considers suicide as a retrospective murder or an aggression turned in-wards, more recent studies suggest that the motivations to commit suicide may vary and are often too obscure. Neurobiological data suggest that low brain serotonin activity might play a key role along with the tryptophan hyroxylase gene. Social factors include social support networks, religion etc.

It is proven that most suicide victims had asked for professional help just before committing suicide, however they were either not diagnosed (particularly males) or the treatment they received was inappropriate or inadequate. The conclusion is that promoting suicide prevention requires the improving of training and skills of both psychiatrists and many non-psychiatrists and especially GPs in recognizing and treating depression and anxiety….The proper use of antidepressants, after a careful diagnostic evaluation, is important and recent studies suggest that successful acute and long-term antidepressant pharmacotherapy reduces suicide morbidity and mortality."]

Full text at: http://www.annals-general-psychiatry.com/content/pdf/1744-859X-6-23.pdf

[Request #S07-106-861]

TRAUMA /POSTTRAUMATIC STRESS DISORDER

"Access to Community Mental Health Services: A Study of Adult Victims of Trauma." By Lucille Schacht, NASMHPD Research Institute, and others. IN: Best Practice in Mental Health: An International Journal, vol. 3, no. 2 (Summer 2007) pp. 1-8.

["Access to community mental health services for adults with a history of trauma is an important area of concern. This paper examines utilization of community services by more than 4,000 individuals in four states who either had an inpatient diagnosis of post-traumatic stress disorder or experienced an inpatient seclusion/restraint. Although both groups are identified with an inpatient stay, the types of trauma are different in important

ways. The analysis relies exclusively on administrative data from inpatient and community programs. Findings indicate that individuals who had been restrained or secluded were substantially more likely to access community services than individuals with an inpatient diagnosis of PTSD. Women were substantially more likely than men to access community mental health services, regardless of the type of trauma. There was little variation among states in access to community services for each type of trauma. This research provides an efficient, nonintrusive model to use existing data resources to evaluate access to care, practice patterns, and treatment outcomes for individuals with a history of trauma."]

Full text at:
http://search.ebscohost.com/login.aspx?direct=true&db=a9h&AN=26057751&site=ehost-live

[Request #S07-106-862]

"Treating Adults with Acute Stress Disorder and Post-Traumatic Stress Disorder in General Practice: A Clinical Update." By David Forbes, University of Melbourne, and others. IN: Medical Journal of Australia, vol. 187, no. 2 (July 16, 2007) pp. 120-123.

["General practitioners have an important role to play in helping patients after exposure to severe psychological trauma. In the immediate aftermath of trauma, GPs should offer "psychological first aid", which includes monitoring of the patient's mental state, providing general emotional support and information, and encouraging the active use of social support networks, and self-care strategies.

Drug treatments should be avoided as a preventive intervention after traumatic exposure; they may be used cautiously in cases of extreme distress that persists. Adults with acute stress disorder (ASD) and post-traumatic stress disorder (PTSD) should be provided with trauma-focused cognitive behaviour therapy (CBT). Eye movement desensitisation and reprocessing (EMDR) in addition to in-vivo exposure (confronting avoided situations, people or places in a graded and systematic manner) may also be provided for PTSD. Drug treatments should not normally replace trauma-focused psychological therapy as a first-line treatment for adults with PTSD.

If medication is considered for treating PTSD in adults, selective serotonin reuptake inhibitor antidepressants are the first choice. Other new generation antidepressants and older tricyclic antidepressants should be considered as second-line pharmacological options. Monoamine oxidase inhibitors may be considered by mental health specialists for use in people with treatment-resistant symptoms."]

Full text at: http://www.mja.com.au/public/issues/187_02_160707/for10467_fm.pdf

[Request #S07-106-863]